

An ethics framework for healthcare services provided to refugees

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ABSTRACT

Around 30 million people in the world have had to change their residence due to political, social, economic, or natural reasons. As a normal result of displacement, these people change the physical, economic, and sociocultural dynamics of their place of destination and are affected by these dynamics more than the local citizenry. These people are labeled as migrants, refugees, or asylum seekers and face numerous problems while utilizing basic human rights such as access to food, accommodation, security, education, and healthcare. Most of these people have to struggle with numerous health problems, namely physical violence, injuries, nutritional disorders, stunted growth in children, infectious disease, chronic diseases, abuse, and mental disorders. Host countries try to meet these demands within contingent bounds. This study addresses the healthcare needs of refugees and the problems they encounter when utilizing healthcare services within the scope of an ethical framework. Given the fact that healthcare resources are limited and their demand can continuously increase, clearly not every produced solution will provide the ultimate benefit. However, the criteria to reference in the distribution of resources should be examined, discussed, and decided upon using an ethical approach.

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Refugees and Healthcare Services

Throughout history, people have moved their residence and changed their settlement. This movement is sometimes voluntary and sometimes obligatory. Migration is defined as the displacement of people due to political, socioeconomic, or natural reasons. Migration can take on forms such as voluntary *vs.* compulsory, temporary *vs.* permanent, internal *vs.* external, and individual *vs.* mass (Adıgüzel, 2016, pp. 1–3). Physical, economic, and sociocultural dynamics are likely to change following the experience of migration.

In order to have a better understanding of refugees' health status, which constitutes the central part of this study, the concepts of immigrant, refugee, and asylum seeker need to be positioned correctly. An immigrant is typically defined as a person who immigrates to another country in order to improve their financial and social conditions and prospects both for themselves and their family without no direct pressure being present in their

decision to migrate. According to the Geneva Convention signed in 1951, a refugee is one who lives outside the country of origin, cannot benefit from the rights of their own country, or is unable or unwilling to return to the country of origin due to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion. Meanwhile, an asylum seeker is one who has left their country but has not yet been legally recognized as a refugee and is waiting to receive a decision on their claim for asylum (Adıgüzel, 2016, pp. 5–6).

The United Nations High Commissioner for Refugees (UNHCR) reported a total of 26 million refugees and 4.2 million asylum seekers to exist in the world as of the end of 2019, with more than half being under the age of 18. Of these, 57% are refugees from three countries: Syria (6.3 million), Afghanistan (2.6 million), and South Sudan (2.4 million). In the same report,

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Turkey was declared as the country hosting the largest refugee population in the world at around 4 million people, followed by Uganda (1.4 million), Pakistan (1.4 million), Lebanon (1 million), and Iran (0.9 million; UNHCR, 2020).

According to reports from the Turkish Republic Interior Ministry Directorate General of Migration Management, 3,653,619 Syrian nationals have been provided with temporary protection, and approximately 58,000 refugees have been provided with settlements in tent cities in Turkey as of February 10, 2021. Of Turkey's provinces, Istanbul hosts the largest number of Syrian nationals (520,000), followed by Gaziantep, Şanlıurfa, Hatay, Adana, and Mersin. Additionally, the distribution of age groups in children under 18 years of age is as follows: 0-4 years (499,000), 5-9 years (558,000), 10-14 years (419,000), and 15-18 years (253,000; Directorate General of Migration Management, 2021).

Health Problems Faced by Refugees

In addition to health problems, refugees who've been suddenly displaced without their consent are likely to face physical, economic, and social problems at their destination. In particular, women and children (i.e., the disadvantaged and vulnerable population) are likely to experience more health problems. These health problems may be listed as (Karadağ & Altıntaş, 2010):

- Nutritional disorders,
- Stunted growth and development in children,
- Anemia,
- Infectious diseases such as diarrhea, measles, malaria, and respiratory tract infections,
- Physical violence and related injuries,
- Sexual abuse,
- Sexually transmitted infections,
- Unintended pregnancies, risky pregnancies,
- Miscarriages, birth complications,
- Chronic diseases,
- Mental problems, predominantly including depression, anxiety disorders, sleep disorders, and post-traumatic stress disorder,
- Dental problems.

Refugees living under poor conditions have greater and more specific health needs compared to individuals living under normal conditions due to various reasons such as higher risk of getting sick and delayed recovery from diseases. The host country provides the necessary services to meet these requirements.

The fundamental problem in providing healthcare services to refugees is the difficulties these individuals experience accessing healthcare services due to legal and physical constraints. Additionally, these challenges are further intensified by problems such as inadequacy of healthcare personnel, cultural and linguistic incompatibilities, inability to adapt to a new healthcare system, and paid healthcare services (Karadağ & Altıntaş, 2010).

An Ethical Framework for Refugee Healthcare

The Philosophical Foundations of Refugee Healthcare

The concept of rights and human rights. The concept of rights is a legal term used for expressing a moral situation. In a general sense, however, rights refer to the justified claims or demands made on a person, institution, or other. Accordingly, possessing a right to something means the person who is assumed as the owner of that right is authorized to act or demand something legitimately; it also indicates the indisputability of the claims and demands made on that thing and the necessity of that right to be recognized and respected by all. Additionally, it also requires all parties to

agree on that issue. In line with these notions, the elements of rights are gathered under three headings: power, demand, and obligation to respect. Of these, power refers to the authority to act and indicates the holder of the right to be free to act or not act. Demand refers to the right holder's authority to make a positive or negative request. Obligation to respect, on the other hand, requires others to respect the legitimate right with regard to fulfilling the demands of the right holder (Erdoğan, 2007, pp. 7–12).

The question of where the right to make a claim originates from is another area of debate. One of these sources are contracts, which entitle a person to be able to act. Through a contract made between two persons or between a person and an institution, one party obtains a right and the other party undertakes an obligation. Legal rules are the second source of the right to make a claim. In these legal rules, a previously made contract may also be taken as reference. Legal rules such as a constitution, laws, or regulations can entitle a person to act or legitimize some of their claims. The third source of the right to make a claim is the notion regarding the correctness or justifiability of an act or claim; this shows the moral legitimacy of the claim (Uygun, 2000).

In legal terms, a right is always accompanied by a corresponding duty. These duties can be negative or positive depending on the nature of the right in question. Negative rights belong to the individual and cannot be prevented or infringed upon by the government (i.e., freedom of conscience, freedom of thought, and inviolability of residence). Positive rights are accepted as matters of rights that individuals are entitled to demand directly from a government, including rights to health, education, and social security (Dursun, 2009). On the other hand, a right may not always have a corresponding moral duty, which is particularly the case in non-legal contexts. To illustrate, being philanthropic or saving a person from pain is a moral duty; however, this duty does not create a right in favor of the recipient. Therefore, the duty-right relationship requires legal obligation but not a moral one, and the fulfilment of this obligation may only be claimed on the basis of a predetermined legal agreement. Erdoğan (2007, p. 17) embodied this issue with the following example:

As a matter of fact, when a person is practically benefiting from a service, they may not have the right to demand it again when this service is terminated against their will. This situation is particularly important for social rights.

Human rights are unique rights that have been acquired throughout history and may be defined as the rights a person possesses simply because they are human. The notion of ethics is the source of these rights. Moreover, these rights, categorized as moral rights, are considered superior to other moral rights as the fundamental value protected by human rights is the quality of being human. Sustaining this quality and leading a humane life is possible by securing these rights (Uygun, 2000). Human rights comprise the minimum conditions for a “dignified” life (Donnelly, 1995, p. 27). Although this notion has gone through many stages throughout history and has been principally adopted by governments and individuals, it contains many practical problems. Legal rights provide the basis for claims to protect established legal powers. For this reason, these rights are based on the products put forward by the creators of the structures known as laws. Meanwhile, human rights constitute the moral basis of strengthening legal powers within the existing system or of creating new systems or even checking existing ones. In this regard, legal rights and human rights function differently from each other (Donnelly, 1995, p. 26), mainly because these rights may not always be subject to legal processes or suitable enough to be developed and regulated in such a way as to cover all individuals.

The Universal Declaration of Human Rights was adopted by the United Nations General Assembly (UN) on December 10, 1948. Grounded on the preamble of “Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world”, the Declaration consists of 30 articles, of which Article 25 relates to the right to social services and medical care (UN, 1948). The rights indicated in these articles are accepted as fundamental human rights, and these articles appear to have been compiled through a collective contribution from religions, political struggles, philosophers, and artists that have guided societies.

Views also exist against the human rights theory. The precursor of this opposition is the legal positivism theory, which denies that humans have inherent rights and posits that a right arises from mutual agreement as a requirement of social contract. The theory also argues that when a right or a freedom does exist, it is something that has been brought about through laws. Therefore, human rights are not inherent but the result of a contract and may only exist in union with the society (Karagöz, 2002).

Right to health. The World Health Organization (WHO, 1946) defined the concept of the right to health as the right to complete physical, mental, and social well-being. In accordance with this definition, WHO (1978) intensified the emphasis on “complete well-being” by adding the expression “not merely the absence of disease or infirmity” to its definition of health.

The right to a healthy life was mentioned for the first time in Western countries in Thomas More’s *Utopia* in the early 16th century. According to More, to ensure a healthy life in a country, the government and society have to take the necessary measures (Alptekin, 2004). In *Utopia*, the elderly and the sick are shown great compassion, cared for with utmost affection, and treated compassionately in large and well-organized hospitals outside the city (More, 2005, p. 42).

The right to health is considered among the second-generation of social rights and positive rights. Due to its classification as a positive right, individuals can claim the right to health from their government (Temiz, 2014). Defined as a right that ensures the protection and development of individuals’ well-being, the right to health requires the existing healthcare system to preserve individuals’ health to prevent them from becoming ill, to provide qualified medical care and treatment equally to every individual, and to ensure easy access to all of these services (Alptekin, 2004). In other words, the right to health as an ethical principle involves being accessible, equal, and fair for every individual (Atıcı, 2006). In addition, according to the International Covenant on Economic, Social and Cultural Rights adopted by the United Nations (1966) (OHCHR), the right to health has a freedom dimension as well. Accordingly, this freedom includes the right to control one’s health and body, including sexual and reproductive freedom, and the right to be free from interference (Temiz, 2014).

The right to health involves four essential elements related to healthcare services: (i) availability, which requires public health and healthcare facilities as well as their medical and professional personnel and the capacity to be available in sufficient quantity; (ii) accessibility, which refers to providing access to physical and economic opportunities and information without discrimination, (iii) acceptability, which refers to healthcare services that adopt a standard in compliance with ethical and cultural codes as well as medical and human needs, and (iv) quality, which requires health facilities, goods, and services to be scientifically and medically appropriate and of good quality (Kol, 2015). Individuals are provided with the right to complete and sufficient health when these four elements are combined.

The right to health is challenged by those who do not consider social rights to be fundamental human rights. This challenge is primarily based on the question as to whether a government is able to obligatorily spend the taxes collected from tax payers on providing healthcare services to individuals that the highest tax-payers may not like or approve of (Temiz, 2014). The responses provided to this question mainly focus on the concept of social benefit, which suggests that an individual’s poor health affects their educational success and other social relationships, thereby reducing their productivity and overall utility, ultimately leading to inequalities in the distribution of wealth and affecting the social peace in general (Yüksel Arabacı, 2009). As seen in the notions mentioned above, the right to health is advocated not as a right based on the notion of being human, but on its outcomes and the total benefit arising from these outcomes. However, these rights may not be limited to the individual sphere. For instance, diseases such as epidemics affect not only the individual but also the entire region and society regardless of the health level of the individual or the general population.

Ethical Rules for Health Aid

In addition to the international regulations that form the basis of the assistance provided to refugees, the regulations that define the ethical rules to follow while providing this aid are highly important in guiding the implementation of this assistance. To this end, numerous regulations have been proposed to date that can be taken as reference, including the Sphere Project; the People in Aid Code of Good Practice; the Code of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGOs) in Disaster Relief; and the Core Humanitarian Standard on Quality and Accountability.

The Sphere Project. In 1996 after the acknowledgment of concerns about humanitarian efforts, the Sphere Project was launched by NGOs as the first joint venture to produce globally applicable minimum standards for humanitarian aid. The goal of the Sphere Project was to increase the effectiveness of humanitarian efforts and accountability in the humanitarian system. This project is primarily aimed at people who have the right to protection and assistance in disasters, as well as NGO members and donors. The fundamental principles of the project are as follows:

- Every individual has the right to timely and appropriate health care.
- The goal of healthcare system in a crisis is to reduce morbidity and mortality.
- Existing healthcare systems should be supported and improved.
- Urban crises require a different approach to health action.
- Maintaining close cooperation with other sectors should be encouraged.
- International law primarily protects the right to health.
- Humanitarian organizations should consider the risks and advantages regarding the way they configure their services and how this affects public trust and acceptance.

The healthcare system standards devised by the Sphere Project are as follows:

- People must have access to integrated quality healthcare that is safe, effective and patient-centered,
- People must have access to healthcare workers with adequate skills at all levels of healthcare,
- People must have access to essential medicines and equipment,
- People must have access to free priority healthcare for the duration of the crisis,
- Healthcare must be guided by evidence through the collection, analysis, and use of relevant public health data.

The project also devised standards in the field of essential healthcare for communicable diseases, child health, sexual and reproductive health, injury and trauma care, mental health, non-communicable diseases, and palliative care (The Sphere Project, 2011).

The people in aid code of good practice. This code includes principles that offer aid agencies an effective framework for human resource management, helping them assess and raise their performance. These principles are as follows:

Principle 1: Human Resources Strategy. Human resources are an integral part of our strategic and operational plans.

Principle 2: Staff Policies and Practices. Our human resources policies aim to be effective, fair, and transparent.

Principle 3: Managing People. Good support, management, and leadership of our staff is key to our efficacy.

Principle 4: Consultation and Communication. Dialogue with staff on matters likely to affect their employment increases the quality and efficacy of our policies and practices.

Principle 5: Recruitment and Selection. Our policies and practices aim to attract and select a diverse workforce with the skills and capabilities to fulfill our requirements.

Principle 6: Learning, Training and Development. Learning, training, and staff development are promoted throughout the organization.

Principle 7: Health, Safety and Security. The security, good health and safety of our staff are a prime responsibility of our organization (People in Aid, 2003).

The Code of Conduct for the International Red Cross and Red Crescent Movement and non-governmental organizations in disaster relief. This code was developed through a joint collaboration of the International Committee of the Red Cross (ICRC) and the International Federation of Red Cross and Red Crescent Societies (IFRC). This code seeks to safeguard high standards of behavior and maintain independence and effectiveness in the aid provided by both NGOs and the Red Crescent and Red Cross in disaster relief. These rules, however, are not binding but are enforced by the will of the organizations that accept it for maintaining the standards it lays down. The code consists of the principles of conduct for relief aid and also involves recommendations for the disaster-affected state, the donor state, and international organizations. This code states the following principles:

- Providing humanitarian aid to people affected by disasters is imperative.
- Aid is provided regardless of the language, race, religion, or nationality of the recipients and aid priorities are calculated on the basis of need alone.
- Aid shall not be used for political or religious purposes.
- The aid provided by other countries shall not be used as instruments of government foreign policy.
- The culture, structures, and customs of the communities and countries to be aided shall be respected.
- Attempts shall be made to build disaster response based on local capacities.
- Ways shall be found to involve program beneficiaries in the management of relief aid.
- Relief aid must strive to decrease future vulnerabilities to disaster as well as to meet the basic needs of the people affected by the disaster.
- Aid organizations are accountable to both those who seek and those who provide aid.
- In all publicity and advertising activities, disaster victims must be portrayed as dignified humans, not hopeless objects (ICRC & IFRC).

The core humanitarian standard on quality and accountability. The Joint Standards Initiative (JSI) was established by a joint venture of the Humanitarian Accountability Partnership (HAP), People in Aid, and the Sphere Project to simplify and facilitate how aid workers implement standards. The Core Humanitarian Standard on Quality and Accountability (CHS) emerged as a direct result of JSI.

The CHS involves nine commitments that organizations and individuals are recommended to fulfill during humanitarian response. These organizations are expected to improve their systems, structures, and practices in order to continuously improve the quality and accountability of the humanitarian aid they provide. However, because a wide variety of organizations and individuals are found engaged in humanitarian aid activities, all of them need to act in a timely manner and adapt their activities both to the capacities and requirements of their organizations as well as to the stages and conditions of the crisis they are in (CHS Alliance et al., 2014). The nine commitments are as follows:

1. Communities and individuals affected by crisis should receive assistance appropriate and relevant to their needs.
2. Communities and individuals affected by crisis should have access to the humanitarian assistance they need at the proper time.
3. Communities and individuals affected by crisis should not be adversely affected and be more prepared, resilient and less at-risk as a result of humanitarian action.
4. Communities and individuals affected by crisis should know their rights and entitlements, have access to information, and participate in the decision-making processes that affect them.
5. Communities and individuals affected by crisis should have access to safe and responsive mechanisms to handle complaints.
6. Communities and individuals affected by crisis should receive well-coordinated and complementary assistance.

7. Communities and individuals affected by crisis should be able to expect delivery of enhanced assistance as organizations learn from experience and reflection.
8. Communities and individuals affected by crisis should receive the assistance they require from competent and well-managed staff and volunteers.
9. Communities and individuals affected by crisis should be able to expect that the organizations providing aid to them are managing resources effectively, efficiently, and ethically.

Health Benefits within the Framework of the Basic Principles of Medical Ethics

Two main sources are found for the principles upon which biomedical ethics are built. The first is the Belmont Report (1979) and its relevant publications as created by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, and the second is the book *The Principles of Biomedical Ethics* (Beauchamp & Childress, 1979). Beauchamp and Childress devised four principles: (1) Respect for autonomy (i.e., the right for an individual to make their own choice); (2) Non-maleficence (i.e., do no harm); (3) Beneficence (i.e., maximize possible benefits and minimize possible harms; balance benefits against risks); and (4) Justice (i.e., performing an equitable distribution of benefits, risks, and costs).

Respect for autonomy. Two basic conditions exist regarding autonomy: voluntariness (i.e., independence from factors influencing control) and competency (i.e., the capacity for voluntary action; Beauchamp & Childress, 2017, p. 154). When making decisions on behalf of refugees struggling to survive under difficult conditions, their freedom should not be limited, and maximum effort should be exerted to allow them to use their capacity of action voluntarily. To achieve this, their language restrictions should be eliminated first. The most effective way to allow them to achieve autonomy is to obtain their informed consent (i.e., they should be informed clearly and understandably when making a choice regarding their healthcare processes). However, this information-sharing activity should in particular employ expressions from refugees' mother tongue and should not overuse medical terminology.

On the other hand, some cases may occur in which the autonomy of the individual is violated for the sake of public health. Infectious diseases constitute a good example of this phenomenon. Although near consensus exists on the compulsory treatment of infectious disease, this treatment, particularly vaccinations, has become controversial in the prevention of disease. Accordingly, several questions need to be addressed: Can parents decide on the vaccination of their children who have not yet caught a disease but are likely to catch and whose self-efficacy has not yet developed, and can the refugees living in host countries that grant their citizens the right to refuse vaccination be exempted from this right?

Non-maleficence. In medical practice, *primum non nocere* (First, do no harm) has been considered for ages as the principal precept for ethical decision-making. This principle takes precedence over other principles as it directly concerns the person and mainly because this principle is the first result of direct interaction between the medical service provided and the person (Beauchamp & Childress, 2017, p. 227).

No controversy exists in medical ethics regarding the prevention of harm or evil; the discussion is about what is harmful. Consequentialists, natural law ethicists, deontologists, virtue ethicists, and ethical egoists have attempted to define what harm is through the perspective of their systems of thought (Summers, 2009). The main point here is that the perception of a threat to the physical existence of the person should be defined as the first level of harm, and the principle of non-maleficence should be applied within this framework.

In migration and asylum-seeking procedures, the process is not always robust. Some refugees reaching the host country arrive injured. When performing interventions in such patients, the principal precept should be to avoid harming the injured before providing benefit. In addition, the concept of harm should crucially coincide with the person's perception of threat. What is perceived as harm can vary across cultures, and this difference should be taken into consideration. Moreover, this difference also falls within the scope of respect for autonomy.

Beneficence. Beneficence as a principle considers being helpful to others a moral imperative. Moreover, as a principle requiring engaging in beneficent acts, it posits that human beings are morally obligated to take positive and direct steps in helping others. This principle targets being as “good” as possible for as many people as possible (Summers, 2009). Accordingly, the main goal is to increase benefit and reduce harm.

Some moral actions are imperative while others are optional. However, defining the border between these two types of action is not easy. Therefore, exemplifying this subject using the aid organizations that constitute the focal point of this study may be more explanatory. For instance, some aid organizations expect people with a potential to help in reaching needy individuals to participate in such organizations. Accordingly, the question to be addressed is “What should be the limit and extent of helpers’ participation in these organizations?” Ethicists have proposed a solution to this problem: “Helping others as long as it does not negatively affect one’s own well-being is a moral necessity for people; however, when an adverse effect emerges, this action turns into a moral choice” (Cullity, 2007 p.20). At this point, special attention should be paid to the distinction between moral obligation and moral choice. When an action to be taken by a person for another person becomes voluntary, it does not require any obligation. In this way, it moves away from ethical criticism and condemnation. However, an objection can be raised regarding the fact that people’s own needs and well-being are different entities. Nevertheless, because the definition of well-being is unclear, the border drawn for well-being will also be unclear. The risk also exists that such a relative reference coincides only with the comfort of the person helping the needy.

Additionally, the attitude to be adopted by the healthcare personnel providing health aid to refugees should be within the framework of the principle of beneficence.

Justice. Resources are the inputs such as capital, manpower, and equipment required for any production. As a principle, justice requires equitable participation in the resources to be used in the field of healthcare as well as the allocated resources being distributed fairly, honestly, and equally according to need (Aydn & Ersoy, 1994). Due to the limited resources in the field of healthcare, the transfer and distribution of resources to individuals with equal needs is the subject of ethical debate.

Healthcare services provided to refugees, particularly to those with no health insurance who at times pay no fees for services, are the subject of criticism. In situations where no equal participation occurs in costs and large numbers of applicants exist due to negative physical and social environments, objections may arise regarding the distribution of resources. Most of the disadvantageous characteristics regarding refugees’ living conditions can be observed in the living conditions of low-income social classes as well (i.e., including inequality in health insurance premium payments and in access to healthcare services, demanding more healthcare).

At this point, accurately determining the priorities in the distribution of limited resources is highly important. Measures should first be taken against the factors that may adversely affect public health. The primary way to achieve this is to augment and enhance primary healthcare services. Vaccinations, pregnancy/child follow-ups, early diagnoses, and fighting against obesity and addiction are the primary measures for preventing future health risks and healthcare costs resultantly.

The importance of the concept of justice especially increases in specific and costly treatments and medications. Accordingly, the question “In cases requiring intensive care, burn treatment, and orphan drugs, how will the choice be made between a citizen and a refugee with the same need?” may be probed.

The primary view in the distribution of resources is related to the value of life. This view suggests that some people are more valuable to society, to their families, or to themselves. A choice to be made regarding this issue depends on this value. However, the question to probe now becomes “Who will determine which of these values will be prioritized?” The second most-preferred view relates to individuals’ responsibilities regarding their own health. In that case, individuals can make their own choices based on their lifestyle, eating habits, harmful habits, sexual preferences, and travel preferences. On the contrary, several questions may arise regarding this issue such as “What will be the treatment or service criteria to be applied to an individual who does not do what their health requires of them?” and “Do individuals always determine their lifestyle in line with their own preferences?” The third most-preferred view concerns the moral character of the person and is addressed by the following questions: “Who will determine the mor-

al criterion?”, “How will the healthcare personnel act when given a choice about an individual who does not comply with the moral criteria?”, and “In case of a simultaneous emergency in a hospital and a prison, which one should the ambulance head for first?” The fourth most-preferred view is about non-personal traits; choosing patients for scientific research purposes or simply because they are a member of a certain group is also included in non-personal traits (Harris, 2001).

Another approach is related to the utilization of health services. The degree of need in healthcare is measured according to the degree of health service utilization using the scale known as the Quality-Adjusted Life Years (QALY). This measure is used to assess the benefits obtained from medical procedures and to evaluate both the quality and duration of the process experienced during the disease. Accordingly, a QALY of 1 equates to a year spent in perfect health whereas 0 equates to death. In particular, calculating the total QALY score of a patient after treatment improves the efficiency of the distribution of limited healthcare services, thereby providing a common ground for performing a financial assessment as well as for merging the parameters of life expectancy and quality of life into a single unit (Şahin et al., 2012)

Nonetheless, all the views mentioned above are ethically controversial, mainly because the value of life is something that cannot be determined or measured precisely and every individual is inclined to consider their own life more valuable than others’.

Discussion and Conclusion

Making an assessment about healthcare services provided to refugees is often extremely difficult. The main reason for this difficulty is that healthcare services are produced from limited resources. In particular, the rapid pace of migration and sudden population increase have directed attention to this area more intensely. Hospitality and benevolence are cultural traditions that also require economic action. Sudden and catastrophic changes that occur during the implementation of these traditions are not expected to be easily adopted. Therefore, the social and economic changes that have a visible effect on the entire society should be properly discussed and elucidated.

The plurality of ethical dilemmas sometimes pushes societies to make contracts. Conventions such as the Universal Declaration of Human Rights, which is one of the first examples, posit that everyone has the right to benefit from healthcare services. In addition, governments enact laws and regulations to resolve the dilemmas in their own systems. Even though these laws and regulations are binding, they are not indisputable.

Although helping other people seems like a moral duty, whether this task is an obligation or a choice remains unclear, as discussed in previous sections. Even if a person is acknowledged as having the right to receive an appropriate and efficient healthcare service just because they are human, how does one legitimize the burden on the person providing this service? In a legal system where provisions such as taxes and fees are sought in return for the healthcare service provided, how can those who pay and those who do not pay receive equal healthcare services? Can concepts such as beneficence, benevolence, and voluntariness be adopted by the whole society? Does a citizen who has contributed to the total cost of healthcare services through their tax payments have the right to object to such a distribution method? Most importantly, how will choices be made between a host (i.e. citizen) and a refugee who have equal needs in the presence of limited resources? Is it possible to achieve equality in such situations?

The major difficulty arising in the debates regarding medical ethics stems from the perception that each individual is accepted as being as valuable as any other individual. Individuals with political, economic, or social influence essentially deserve a “dignified” life. The sociodemographic background of an individual is not a sufficient reference for preference. Accordingly, being a refugee or a victim of war is not an individual choice, just as having a high socio-economic status is not an individual choice. This distinction should not just be limited to being a refugee. Moreover, the distinction between individuals with different social statuses that live in the same city also cannot be attributed to personal preference. For these reasons, in the presence of limited resources, ethical evaluation should be in reference to health service utilization, regardless of the characteristics of the recipient. Additionally, the principle of justice should be the primary principle to consider when performing this evaluation. In doing so, the decisions made will be more ethically defensible.

Ethical approval

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